Managed Risk Medical Insurance Board
July 13, 2011, Public Session

Board Members Present:	Cliff Allenby (Chairman) Richard Figueroa Samuel Garrison Ellen Wu, MPH
Ex Officio Members Present:	Katie Marcellus, Designee for the Secretary of the Health and Human Services Agency
Staff Present:	Janette Casillas, Executive Director Terresa Krum, Chief Deputy Director Shelley Rouillard, Deputy Director, Benefits & Quality Monitoring Ernesto Sanchez, Deputy Director, Eligibility, Enrollment & Marketing Jeanie Esajian, Deputy Director, Legislative & External Affairs Laura Rosenthal, Chief Counsel, Legal Seth Brunner, Senior Staff Counsel, Legal Heather Wallace, Senior Staff Counsel, Legal Tony Lee, Acting Deputy Director, Administration Thien Lam, Assistant Deputy Director, Eligibility, Enrollment & Marketing John Symkowick, Legislative Coordinator, Legislative & External Affairs Sarah Soto-Taylor, Supervisory Manager, Special Projects Eligibility, Enrollment & Marketing Ruth Jacobs, Assistant Deputy Director, Benefits & Quality Monitoring Brian Warren, PCIP Manager, Benefits & Quality Monitoring Koysharn Lee, Staff Services Analyst, Legal Aiming Zhai, RA II, Benefits & Quality Monitoring Marcia Schiller, Program Specialist I, Benefits & Quality Monitoring Maria Angel, Executive Assistant to the Board and the Executive Director Elva Sutton, Board Assistant

10:05 A.M.

Chairman Cliff Allenby called the meeting to order at 10:05 a.m. The Board adjourned into Executive Session and resumed the Public Session at 11 a.m.

Chairman Allenby introduced Ellen Wu, the Board's newest member, appointed by the state Senate. He also announced the appointment of Terresa Krum as Chief Deputy Director of MRMIB.

REVIEW AND APPROVAL OF MINUTES OF JUNE 15, 2011 PUBLIC SESSION

The minutes were approved with one abstention (Board Member Wu).

The June 15, 2011 Public Session Minutes are located at:
http://mrmib.ca.gov/MRMIB/Agenda_Minutes_071311/Agenda_Item_3_Public_Minutes_6_15_11_FINAL.pdf

FEDERAL BUDGET, LEGISLATION AND EXECUTIVE BRANCH ACTIVITY (Including Healthcare Reform & Budget)

Jeanie Esajian, Deputy Director for Legislative and External Affairs, presented Agenda Item 4, Federal Budget Legislation and Executive Branch Activity, which contained one item of interest for Board reading.

Chairman Allenby asked if there were any questions or comments from the Board. Hearing none, he asked if there were any questions or comments from the audience. There were none.

The documents on the Federal Budget, Legislation, et al., are located at:
http://mrmib.ca.gov/MRMIB/Agenda_Minutes_071311/Agenda_Item_4_071311.pdf

EXTERNAL AFFAIRS UPDATE

Deputy Director Esajian presented Agenda Item 5, External Affairs Update. The last 30 day period was an extremely light media period as demonstrated by the report.

Chairman Allenby asked if there were any questions or comments from the Board. Hearing none, he asked if there were any questions or comments from the audience. There were none.

The document on the External Affairs Update can be found at:
http://mrmib.ca.gov/MRMIB/Agenda_Minutes_071311/Agenda_Item_5_MX_7001N_20110718_104236.pdf

STATE BUDGET UPDATE

Tony Lee, Acting Deputy Director for Administration, reported on Agenda Item 6, the State Budget Update. The recently passed budget included MRMIB's final budget amount of $1.6 billion.

While the budget no longer assumes Healthy Families Program subscribers will be transitioned to Medi-Cal, there is language that allows the state Department of Finance to authorize the transfer of MRMIB funding to the Department of Health Care Services. The budget item also states that all transfers will be consistent with transition plans provided to the Legislature, as required in state statute.

The extension of the Managed Care Organization (MCO) tax is not included in MRMIB's portion of the state budget, which leaves a $100 million General Fund shortfall. While the federal fund match has been authorized, without the $100 million in state General Funds, HFP will have a $300 million total shortfall due to the loss of the federal match. The result could be that coverage for all HFP subscribers ceases March 20, 2012. Mr. Lee iindicated staff's understanding that this would be a maintenance of effort violation that would put the state's $35 billion in federal Medicaid funding at risk.

Included in the Board's packet are copies of letters from various stakeholders and health plans responding to the Administration proposal to transition HFP subscribers to Medi-Cal.

Executive Director Janette Casillas clarified that, while HFP is not fully funded in the state budget and funds are only sufficient to operate the program through some time in February, 2012, , the state may not have the ability to close the program. There are many issues involved, such as a maintenance of effort requirement, whether the federal government would allow MRMIB to close the program, etc. This report simply gives the Board a point in time for when the dollars would actually run out. There are many questions and much to discuss with the Administration and the Legislature relative to MRMIB's budget. Additionally, the letters in Agenda Item 6 are letters of concern related to the budget process. They were sent to the Legislature and provided to MRMIB as a courtesy.

Beginning next month, there will be a standing agenda item for Board meetings for a public discussion about health care reform and, in particular, about where the Board believes MRMIB program subscribers – children, pregnant women and others – are best served. Additionally, there are many research reports under way, being funded by many foundations within the state and even out of the state on how subscribers of Children's Health Insurance Programs (HFP in California) are best served. Staff is looking forward to a public discussion about the pros and cons and options for this population.

Chairman Allenby asked if there were any questions or comments from the Board. Hearing none, he asked if there were any questions or comments from the audience. There were none.

The State Budget Update documents can be located at:
http://mrmib.ca.gov/MRMIB/Agenda_Minutes_071311/Additional_Responses_to_Transition_Healthy_Families_to_the_Medi-Cal_Program.pdf and
http://mrmib.ca.gov/MRMIB/Agenda_Minutes_071311/Final_Budget_Overview_2011-12.pdf

STATE LEGISLATION

John Symkowick, MRMIB's Legislative Coordinator, presented Agenda Item 7, State Legislation.

There have been no major changes to the bills being monitored by staff. Staff will continue to monitor bills into the summer recess. When session resumes, bills will move to the Appropriations Committees of the second house. Some technical changes have occurred since the Board received the initial report, and that the earlier report is available to the public by contacting Mr. Symkowick.

Chairman Allenby asked if there were any questions or comments from the Board. Hearing none, he asked if there were any questions or comments from the audience. There were none.

The State Legislative Report is located at:
http://mrmib.ca.gov/MRMIB/Agenda_Minutes_071311/Agenda_Item_7_State_Legislative_Report_7_12_11_FINAL.pdf

PRE-EXISTING CONDITION INSURANCE PLAN (PCIP) UPDATE

Enrollment Report
Thien Lam, Assistant Deputy Director – Eligibility, Enrollment and Marketing, presented Agenda Item 8.a, the Enrollment Report for the Pre-Existing Condition Insurance Plan. At the end of June, there were more than 3,230 subscribers enrolled in the program. This is approximately 12.5 percent more than the total number of individuals enrolled in May. Data as of July 12 reflect an enrollment of more than 3,310 subscribers, with more than 460 new subscribers enrolled in June. There was roughly a six percent increase in subscribers in the "other" category, or subscribers who elected not to provide their ethnicity to the program. As a result, the percentage of subscribers reported as being white also decreased by five percent. There were no other notable changes to the subscribers' demographics or enrollment in the top 10 counties. The program processed more than 740 applications, with more than 21 percent assisted by insurance agents and brokers.

The PCIP Enrollment Report is located at:
http://mrmib.ca.gov/MRMIB/Agenda_Minutes_071311/Agenda_Item_8.a._PCIP_Enrollment_Report_for_June_2011.pdf

Administrative Vendor Performance Report
Ms. Lam reported on Agenda Item 8.b, the Administrative Vendor Performance Report. The administrative vendor met all 16 areas of performance, quality and accuracy standards.

Chairman Allenby asked if there were any questions or comments regarding the report. There were none.

The PCIP Administrative Vendor Performance Report can be found at:
http://mrmib.ca.gov/MRMIB/Agenda_Minutes_071311/Agenda_Item_8.b._PCIP_Adm_Vendor_Board_Report_June_2011.pdf

Third Party Administrator Performance Report
Brian Warren, PCIP Benefits Manager – Benefits and Quality Monitoring Division, reported on Agenda Item 8.c, the Third Party Administrator Performance Report. For the month of June, the third party administrator met or exceeded all of the performance standards.

Chairman Allenby asked if there were any questions or comments from the Board. Hearing none, he asked if there were any questions or comments from the audience.

Beth Abbott, representing Health Access, noted that she had congratulated Ernesto Sanchez, Deputy Director – Eligibility, Enrollment and Marketing, for increasing PCIP enrollment. However, enrollment is now at only 3,300. She noted proposed language by the Department of Insurance in conjunction with the Department of Managed Health Care, requiring insurers to notify consumers who are denied by a carrier that they may be eligible for PCIP or the Major Risk Medical Insurance Program. She criticized the letters are being passive and said MRMIP was listed first, even though there is a cap on that program and there are greater efforts to increase enrollment in PCIP. She said Health Access would like insurers to provide MRMIB with the names of people who have been declined for health coverage who are eligible for PCIP so that MRMIB could use the information for outreach. Ms. Abbott urged the Board to use other more creative options in outreach and asked for an update on the progress of outreach efforts. She noted the daunting nature of the task to enroll everyone who is eligible for PCIP.

Chairman Allenby asked MRMIB Chief Legal Counsel Laura Rosenthal to comment on Ms. Abbott's suggestion to have the insurance industry provide MRMIB with a list of declined applicants. Ms. Rosenthal indicated that any requirements on insurers and health plans would have to come through their regulators and regulatory structure. She said the assumption would be that personal health information could not be provided without statutory changes, due to state and federal privacy laws. In any case, MRMIB probably does not have the authority to require this action. Mr. Allenby asked staff to communicate the concerns raised by Ms. Abbott. Janette Casillas, MRMIB Executive Director, said that staff would reach out to the regulators and discuss these issues.

Ms. Rosenthal further noted that the current requirement mentioned by Ms. Abbott, that insurers notify declined applicants of options with PCIP, was put into statute as part of the state PCIP law of last summer.

Board Member Richard Figueroa said that perhaps something could be done to the notification letters to make the information more visible or noticeable so recipients would better attend to the letters' contents, especially if this is the only notification received by these individuals.

Ms. Rosenthal said staff would contact the regulators, each of which issues its own letters. Ms. Casillas said staff would report back to the Board at the next meeting.

The PCIP Third Party Administrator Performance Report is located at: http://mrmib.ca.gov/MRMIB/Agenda_Minutes_071311/Agenda_Item_8.c._PCIP_TPA_Performance_Report.pdf

Other Implementation Issues

Subscriber Premium Reductions

Ms. Casillas reported on Agenda Item 8.d.i, Subscriber Premium Reductions. Consistent with federal guidance from the U.S. Health and Human Services Agency, which allowed states to use different methodologies for developing subscriber premiums, staff has been exploring these methodologies and believes one approach would allow the Board to reduce subscriber premiums. Staff was hoping for federal approval to proceed with the reductions prior to today's meeting.

However, approval is still pending. She explained that the premium reductions aresignificant and would affect all subscribers in the program. Ms. Casillas asked for Board permission, pending receipt of federal approval to implement the reductions as soon as possible to benefit subscribers. She said the new premiums will be provided to the Board and the public at the next meeting.

Chairman Allenby asked if there were any concerns from the Board. Hearing none, he told Ms. Casillas to move forward with implementing the premium reductions.

Insurance Agent/Broker Reimbursement

Mr. Sanchez reported on Agenda Item 8.d.ii, Insurance Agent/Broker Reimbursement. He noted that as part of PCIP outreach, staff wanted to provide the Board with an update on what is going on with the related issue of agent and broker reimbursement nationwide. The federal government, in its federal fallback program, indicated that it will begin paying $100 reimbursements for enrollment in the PCIP program. This is for a successfully completed application. A number of states pay more than $100, some ranging all the way up to $250. Approximately 41 percent of these states pay at least $100 or more for those reimbursements. To date, in California, MRMIB has reimbursed 534 agents at $50 per successful enrollment for a total of nearly $27,000. At $100 per successful enrollment, the reimbursement to brokers would have been approximately $53,000.

Staff is considering a move up to $100, but will bring this item back next month as part of the outreach campaign update for Board action. Staff analysis indicates that, if the agent/broker reimbursement increases from $50 to $100, the rate of assistance may increase from the current approximately 16 percent to approximately 25 percent, for a total reimbursement cost of $83,000 based on current enrollment trends.

Chairman Allenby asked if there were any comments or questions from the Board.

Mr. Figueroa said he appreciated this issue and would expect the federal government to pressure states to increase the reimbursement fee. He said the Board has to consider this change so there isn't a disparity between what the federal government and California are each paying. However, he said he would like to consider a rate change in the context of the larger outreach activity picture that would be presented at the next Board meeting and as a way to enhance outreach efforts.

The High-Risk Pool Agent Compensation Survey is located at:
http://mrmib.ca.gov/MRMIB/Agenda_Minutes_071311/Agenda_Item_8.d.ii_Agent_Compensation_Summary_June_2011.pdf

MAJOR RISK MEDICAL INSURANCE PROGRAM (MRMIP) UPDATE

Enrollment Report

Ms. Lam reported on Agenda Item 9.a, the MRMP Enrollment Report. As of July 1, there were more than 6,630 subscribers enrolled in MRMIP, with more than 200 new subscribers. During the same time period, 205 subscribers were disenrolled from the program. There were no notable changes to the subscriber demographic information in the counties in which they were enrolled.

The MRMIP Enrollment Report is located at:
http://mrmib.ca.gov/MRMIB/Agenda_Minutes_071311/Agenda_Item_9.a._MRMIP_Board_Report_Summary_for_June_2011.pdf

Update on Enrollment Cap and Waiting List

Ms. Lam reported on Agenda Item 9.b, the Update on Enrollment Cap and Waiting List. As of July 9, there were 28 people on the waiting list solely because of deferred enrollment.

The MRMIP Enrollment Cap and Waiting List Update document is located at:
http://mrmib.ca.gov/MRMIB/Agenda_Minutes_071311/Agenda_Item_9.b._MRMIP_Weekly_Wait_List_July_2011_data.pdf

Administrative Vendor Performance Report

Ms. Lam reported on Agenda Item 9.c, the Administrative Vendor Performance Report. The administrative vendor met all of four areas of performance standards.

Chairman Allenby asked if there were any questions or comments. There were none.

The MRMIP Administrative Vendor Performance Report can be found at:
http://mrmib.ca.gov/MRMIB/Agenda_Minutes_071311/Agenda_Item_9.c._MRMIP_Adm_Vendor_Perf_for_June_2011.pdf

2010 Open Enrollment Report

Ms. Lam reported on Agenda Item 9.d., the 2010 Open Enrollment Report. Each year MRMIP holds an open enrollment period, which is from November 1 through November 30. Plan transfers are effective on January 1. Open enrollment packets were sent to subscribers and included a general survey regarding subscriber satisfaction with their MRMIP health plans. More than 6,900 open enrollment packets were mailed. A total of 1.5 percent of subscribers requested transfer to another plan, which was a decrease compared to 2009 open enrollment results, in which 2.8 percent changed plans when Blue Shield became unavailable as a MRMIP plan. In all, 5.7 percent of the subscribers responded to the survey. There was a decrease in the number of individuals responding compared to 2009, when 7.8 percent returned the survey.

Overall, 91 percent said they were satisfied with the service provided by their MRMIP health plan. A total of 97 percent said they were satisfied with the services rendered by their provider and nearly 97 percent said they were satisfied with the services provided by their specialists. Roughly 60 percent indicated that they were changing plans because they could not afford their current MRMIP health plan. This was a 9.5 percent increase compared to 2009 and, as a result, the vast majority of subscribers who transferred plans changed to a lower cost plan. The written report for Agenda Item 9.d contains full details of the plan transfer and the survey responses.

Chairman Allenby asked if there were any questions or comments from the Board. Hearing none, he asked if there were any questions or comments from the audience. There were none.

The MRMIP 2010 Open Enrollment Report is found at:
http://mrmib.ca.gov/MRMIB/Agenda_Minutes_071311/Agenda_Item_9.d._2010%20MRMIP_Open_Enrollment_Report.pdf

Adoption of Regulations Concerning Insurance Agent/Broker Reimbursement

Mr. Sanchez reported on Agenda Item 9.e, Adoption of Regulations Concerning Insurance Agent/Broker Reimbursement. Based on the discussion about Agenda Item 8.d.ii, Insurance Agent/Broker Reimbursement, this item will be deferred to next month's Board meeting.

The Proposed Regulation Concerning Insurance Agent/Broker Reimbursement is located at:
http://mrmib.ca.gov/MRMIB/Agenda_Minutes_071311/Agenda_Item_9.e._ER_4_11_MRMIP_Proposed_Emergency_Regulation.pdf

HEALTHY FAMILIES PROGRAM (HFP) UPDATE

Enrollment and Single Point of Entry Report

Ms. Lam reported on Agenda Item 10.a, the Healthy Families Program Enrollment and Single Point of Entry Report. Enrollment at the end of June was at more than 871,900 children, with more than 25,200 new subscribers. There were no notable changes to the percentage of subscribers enrolled in the top five counties and no significant changes to subscribers' demographic information. Single point of entry processed more than 27,400 applications, with 31.5 percent of these accounting for more than 8,650 applications through Health-E-App app.
The percentage of Certified Application Assistants and public users for Health-E-App is comparable to prior months. More than 71 percent of the applications received at Single Point of Entry were forwarded to the Healthy Families Program.

The HFP Enrollment and Single Point of Entry Report is located at:
http://mrmib.ca.gov/MRMIB/Agenda_Minutes_071311/Agenda_Item_10.a._HFP_June_2011_Summary.pdf

Administrative Vendor Performance Report

Ms. Lam reported on Agenda Item 10.b, the HFP Administrative Vendor Performance report. The administrative vendor continued to meet all 18 areas of performance, quality and accuracy standards.

Chairman Allenby asked if there were any questions or comments from the Board. Hearing none, he asked if there were any questions or comments from the audience. There were none.

The HFP Administrative Vendor Performance Report is located at:
http://mrmib.ca.gov/MRMIB/Agenda_Minutes_071311/Agenda_Item_10.b._HFP_Adm_Vendor_QA_2011_06.pdf

2009 Retention Report

Ms. Lam reported on Agenda Item 10.c, the 2009 Retention Report. This report identifies children who were new subscribers enrolled in HFP from January 2009 through December 2009. Staff tracked the enrollment and retention of these children over a one-year period. In 2009, the program experienced several changes, including premium increases in February and November and February of 2009, and co-payment increases.

During the time period tracked, 15 percent of the children were disenrolled before reaching their first annual eligibility review. Of these, 10 percent were disenrolled for non-payment, a slight decrease over the 11 percent in 2008; and the remaining 5 percent were disenrolled for unavoidable reasons, such as the applicant's request for disenrollment or a child's aging out at age 19.

The other 85 percent of children tracked maintained enrollment for at least one year and made it to their first Annual Eligibility Review (AER(. This is consistent with the 2008 report. However, 9 percent of the children were disenrolled during AER, a decrease compared to the 2008 rate of 12 percent. The reason these children were disenrolled was that seven percent did not provide the required annual eligibility review information and one percent provided AER information, but did not provide additional information requested by the program. Finally, one percent was enrolled into no-cost Medi-Cal.

Overall, staff was pleased to report that the retention rate was 76 percent, a three percent increase over the 2008 retention rate of 73 percent.

The report also identifies specific avoidable and unavoidable reasons why 24 percent of the subscribers' coverage ended. Avoidable disenrollment means that the families could have prevented disenrollment, for example, by turning in AER packets, or sending in premium payments. Unavoidable disenrollment means that the family could not have prevented disenrollment because their children became ineligible

The specific disenrollment reasons of the long-term retention report are also identified, with no overall notable changes of these disenrollment reasons.

Mr. Figueroa noted the shifting of enrollment in and out of HFP because of family income volatility. However, he said the report shows there is not as much volatility if even half of the subscribers are still enrolled five years later. He also asked if there was any information available on what happens to children who disenroll from the program because they do not provide information at AER. For example, did their family gain access to employer-sponsored health coverage or did they become eligible for Medi-Cal?

Ms. Lam said that, after a family is disenrolled, surveys are initiated to learn more about why coverage ended. It is very challenging to get people to respond, but the program does have some general. Mr. Figueroa said it would be interesting for the Board to review the data to find out if families are obtaining coverage elsewhere or becoming uninsured.

Ms. Casillas said staff is not tracking the specific children who were disenrolled ,

but that can be done. She said staff would need assistance from Medi-Cal because it is likely that most HFP disenrollments for non-payment of premiums result from the family's becoming qualified for no-cost Medi-Cal. It is a negative perception that families could not afford HFP. In many cases, their income dropped and they were eligible for no-cost Medi-Cal, which prevents the child from being uninsured. It is important for staff to try to resume discussions on a project through which MRMIB would match HFP disenrollments to see whether those children can be found through data the program already has in place.

Katie Marcellus, ex-officio Board member designated by the Secretary of Health and Human Services, said that the Department of Health Care Services has done some internal work on Medi-Cal and she would be happy to convene a conversation to further this effort of tracking children who leave HFP.

Mr. Sanchez noted that the earlier referenced study was actually a decade old, but the National Association of State Health Plans' research highlighted disenrollments for unavoidable reasons, finding that 60 percent of the time, these subscribers had already found other coverage and their way of letting the program know was to stop paying premiums or not turn in their AER form.

Chairman Allenby asked if there were any other comments or questions from the Board. Hearing none, he asked if there were comments or questions from the audience. There were none.

The HFP 2009 Retention Report is located at: http://mrmib.ca.gov/MRMIB/Agenda_Minutes_071311/Agenda_Item_10.c_07_13_2011.pdf

Update on Oral Health Initiatives

Shelley Rouillard, Deputy Director for Benefits and Quality Monitoring, reported on Agenda Item 10.d, the Update on Oral Health Initiatives, specifically the Healthy Smiles, Healthy Families Oral Health Quality Improvement Project, which was last presented to the Board in February.

The California Healthcare Foundation is funding the project and MRMIB is matching that with Title XXI funds. The Center for Healthcare Strategies is facilitating the project. Since February, the change package was finalized and provides the activities and the priorities that the plans will be following over the next 18 months to increase utilization and improve preventive care services to children, particularly the youngest children up to six years of age.

The project will target four Southern California counties because the dental HMOs are concentrated more in the south and therefore these counties provide the most opportunity for significant improvement. The four counties are: Los Angeles, Ventura, Santa Barbara and San Diego, representing 38 to 40 percent of the Healthy Families population.

The dental plans have formed three work groups and each plan has taken a leadership role in facilitating the work groups.

The provider engagement work group is trying to identify providers who are willing to see and serve young children, particularly children up to age three. Many

general dentists do not have training or are uncomfortable in treating these young children. Safeguard is spearheading a survey of general dentists in the four counties, possibly in conjunction with the California Dental Association, to determine which dentists are interested and willing to serve young children. CDA also has developed a curriculum called The Pediatric World Health Access Program, to train dentists on how to handle the youngest children. Staff is hopeful that at least one or more of these trainings will occur. Western Dental is taking the lead on a preferred provider directory, which will identify all dentists who are willing to serve these very young children. The directory will be available online to help families and pediatricians find dentists to treat very young children. Premier Access is taking the lead on developing a risk-assessment tool that dentists would use to identify children who are at high risk of caries and then conduct appropriate intervention.

Health Net has taken the lead in the medical and dental integration work group, since it is a medical as well as dental plan. This group is developing a referral pad for pediatricians to refer children to dentists. The group is discussing how a referral will be communicated to the dental plan from a pediatric office. Other discussions center on how the pads will be distributed, who will pay for printing and how the pediatrician knows which dental plan the child is in. The dental plans are anxious to meet with the health plan medical directors to brainstorm ideas about integration and how that might work.

Mr. Figueroa said this topic was even more important because the ACA treats pediatric dentistry as an essential benefit that could be covered either through the plan or through an independent dental plan. This issue of integration could also affect the way dental benefits are provided through the Exchange.

The third work group is community engagement and family education. Delta Dental is taking the lead in developing outreach strategies to identify families at risk and is working with community organizations. The work group has reached out to the Archdiocese of Los Angeles and the Hispanic Dental Association, identifying champions that work in community-based programs. Some pediatric dentists in Los Angeles are working with this work group, which is also developing culturally-appropriate educational brochures targeted to families through Head Start, WIC, First 5 Commissions, etc.

In addition to the three work groups, a data workbook has been developed for the plans to use in identifying and tracking quarterly utilization. The plans will be reporting on four measures annually, but they are the four that are prioritized with the HFP Advisory Panel as being the most important for the youngest population. The performance standards are overall utilization of dental services (how many children are seeing the dentist for first-year dental visit); the rate of preventive dental services; the rate of exams and oral health evaluations; and the rate of treatment and prevention of caries.

First quarter 2011 data will be submitted next week, which will become the project baseline from which progress will be measured over the next 18 months. Another area that will be important into the future is how to pay and align incentives to get children in for the one-year dental visit. Depending on how the data evolves with this project, staff will be bringing this item to the Board in the future. Some of these projects are going to require some additional funds.

Ms. Rouillard said she has spoken with the First 5 Commission executive directors in the four study counties about what resources they might have available. The CDA Foundation also indicated an interest in potentially helping with the provider survey. There is a lot of activity around this nationally and staff is on the lookout for future opportunities in these areas.

MRMIB is encouraging the plans to use online media and other cost-saving mechanisms. The plans can pool resources to reduce the impact on any one plan. The plans are working very well together in each work group, even though one plan is taking the lead in coordination of each work group.

Work groups will continue to meet on a monthly basis and there will be an all-plan call on August 4. We will continue to work with First 5, the Dental Association, the California Primary Care Association and the FQHCs, many of which offer both health and dental services. Data analysis will begin on the submitted data mentioned earlier and staff will bring that information to the Board in the next few months.

Chairman Allenby asked if there were any questions or comments from the Board.

Board Member Ellen Wu asked if this project was coordinated with county dental programs and public health programs. Ms. Rouillard said no, but that was a good idea.

Chairman Allenby asked if there were any questions or comments from the audience. There were none.

2009-10 California Children's Services Report

Marcia Schiller, Research Specialist in the Benefits and Quality Monitoring Division, reported on Agenda Item 10.e, the 2009-10 California Children's Services Report. Data for the report came from three sources: the plans, who provided information on the number of referrals over 12 months and the number of active cases as of the last day of the fiscal year; the state California Children's Services office both expenditure and case data; and Healthy Families Program data, which provided enrollee information by plan, age and ethnicity.

Overall, plan referrals from HFP to CCS have increased by 12 percent from the previous year. A total of 86.5 percent of HFP referrals were accepted, and this was an increase of 10 percent from the previous year. The rate of acceptances into the program has increased, while the rate of denials and "pending judgments" has decreased. Referrals by age are similar to previous years; referred children tended to be older than children who were not referred. The annual expenditures for HFP CCS children have dropped 15 percent. Latinos continue to represent the largest percent of enrollees in both HFP groups.

Chairman Allenby asked if there were any questions or comments from the Board.

Mr. Figueroa said he was pleased that the acceptance rate was increasing. He also noted that the overall number of children has been declining. He said the changes made in the most recent contract were designed to make the referral system easier for families to navigate and to coordinate better with counties and

health plans. He said he hoped the Board would continue to work to make this process easy for families.

Ms. Rouillard noted that the average cost per case also has decreased significantly from last year to this year. Staff needs to work with CCS to find out exactly why that happened. Ms. Rouillared opined that it could be due to fewer hospitalizations, which are the most costly aspect of the program.

Chairman Allenby said he was struck by a chart in the report that showed cases as a percentage of health plan enrollment and the wide variation from 4.8 percent to 0.1 percent. The variation would lead to the conclusion that plans are identifying and referring these subscribers differently. Mr. Figueroa noted that there did not seem to be a trend based on what type of plan had a higher versus lower CCS case load.

Ms. Rouillard noted that Appendix C of the report provided actual numbers of cases for each of the plans, while Chart 5 in the report provides the percentage of enrollment.

The HFP 2009-10 California Children's Services Report can be found at: http://mrmib.ca.gov/MRMIB/Agenda_Minutes_071311/Agenda_Item_10.e._CCS_REPORT_2009_2010.pdf

2009-10 Grievance Report

Aiming Zhai, Research Analyst in the Benefits and Quality Monitoring Division, reported on Agenda Item 10.f, the 2010 Grievance Report of the Healthy Families Program. Every year MRMIB requests thatHFP health, dental and vision plans to report grievances filed by HFP subscribers. The report represents calendar year 2010 grievance data.

In 2010, the overall rate of grievance for health plans was 37 per 10,000 HFP members, a decline of 10 percent compared to 2009. Trends can be found in the full report for the years 2008-2010. Quality of
care concerns represent the highest percentage of health plan grievances, at 32 percent. Claims-related grievances represent the second highest percentage, at about a quarter of all grievances.

Dental plan grievances for 2010 averaged 7 per 10,000 HFP members, compared to five per 10,000 in 2009. One-third of dental grievances are benefit- and coverage-related, while quality of care issues are the second most reported grievances, representing one-fourth of all dental grievances.

The rate of grievances for vision plans stayed flat attwo per 10,000 HFP subscribers for the past three years, from 2008 to 2010.

The proportion of grievances by ethnicity and language grouping is generally in line with enrollment statistics, which also are detailed in the full report. English speakers file grievances at a higher rate than those who speak other languages. While Latinos represent almost half of the HFP enrollment, they file only 38 percent of grievances. Whites represent 17 percent of all grievances, even though they make up less than 10 percent of HFP population.

Chairman Allenby asked if there were any questions or comments from the Board.

Ms. Wu asked for an explanation of the claims-related grievances. It seems like the top reason is insufficient payment. Does that mean the plan has not paid the provider and the provider is billing the member?

Ms. Rouillard said that could be the meaning of that statistic, or providers who were not happy with the paymentcould be balance billing. The exact detail is not known.

Mr. Figueroa asked if the type of grievances in HFP could be compared to grievances in private insurance plans. Is there a baseline for comparison?

Ms. Rouillard said this question was raised by the Board last year and staff researched it through the Department of Managed Health Care.Staff found that grievances in private insurance are even lower than in HFP and comprise a very small number. This reporting is directly to the plans, not the regulators. Ms. Rouillard further noted that, regarding Ms. Wu's earlier question, the biggest category of claims-related grievances are for refusal to pay for treatment. These are first-level grievances.

Chairman Allenby asked if there was an effort to dialogue among various public plans to determine what collection of data makes sense, so there is some comparability and means of determining patterns that go across plans. Ms. Rouillard said she was not aware of a statewide effort. However, a more consolidated approach to consumer assistance as an outcome of health care reform may prompt that activity.

Chairman Allenby asked if there were any comments from the audience.

Ms. Abbott of Health Access asked if staff had looked at the language that is used to convey the right to file a grievance in light of the fact that whites report many more grievances proportionately. She said there is great reluctance by plans to have elaborate and sufficient language discussing appeal rights. Perhaps there is unintentional bias that does not give fully afforded rights to people who do not speak English as their first language.

Chairman Allenby said this is something staff should look at. Mr. Figueroa said that general laws addressing language access and translation of documents apply to the Health Families population and emanated from a bill sponsored by Health Access. Ms. Wu said that all health plan grievance and complaint forms should be translated.

Ms. Abbott agreed, but indicated that she was asking if that had actually occurred. Mr. Figueroa asked if HFP had any standards over and above those already required under statute. Ms. Rouillard said that HFP plans are all subject to Knox-Keene requirements. She said staff had not asked the plans for their specific grievance forms.

Ms. Abbott said that, in her experience working for the Centers for Medicare and Medicaid Services, on-site visits would turn up forms for grievances, appeals,

complaints and disputes, etc. She indicated that these forms had very restrictive and narrow definitions in an effort to deter the filing of a grievance that would reflect poorly on plans. Ms. Abbott asked if the grievance information is based on analysis of information reported from the plans to MRMIB and Ms. Rouillard indicated that this was the case. Ms. Abbott asked if that information is validated to determine if it is correct. Ms. Rouillard said that there are no staff resources at this time to carry out this function. However, the Board is going to contract with an External Quality Review Organization, which will be responsible, in part, for checking on issues of this type.

Ms. Abbott applauded that effort and said it was her belief that there is a great tendency in some plans and some circles not to have a grievance reflect a dispute. She said it is important to determine that this is an accurate representation of consumers' complaints.

Ms. Wu said the area of race/ethnicity seemed to indicate concordance in the statistics. Mr. Figueroa said that has been consistently reported for a long period of time.

The HFP 2009-10 Grievance Report is located at:
http://mrmib.ca.gov/MRMIB/Agenda_Minutes_071311/Agenda_item_10.f._%20HFP_2010_Grievance_Report.pdf

ACCESS FOR INFANTS AND MOTHERS (AIM) UPDATE

Enrollment Report

Ms. Lam reported to the Board on Agenda Item 11.a, the AIM Enrollment Report. In June, there were 819 new subscribers . The program has more 7,060 subscribers enrolled. There were no notable changes to the subscribers' ethnicity. Los Angeles, San Diego and Orange continue to be the top three counties of enrollment, which reflects 47 percent of the enrolled population. The health plan enrollments did not change significantly change from prior months.

The AIM Enrollment Report is located at:
http://mrmib.ca.gov/MRMIB/Agenda_Minutes_071311/Agenda_Item_11.a._AIM_June_2011_summary.pdf

Administrative Vendor Performance Report
Ms. Lam reported on Agenda Item 11.b, the AIM Administrative Vendor Performance Report. The administrative vendor continued to meet all seven areas of the performance, quality and accuracy standards.

Chairman Allenby asked if there were any questions or comments on the report. There were none.

The AIM Administrative Vendor Performance Report can be found at:
http://mrmib.ca.gov/MRMIB/Agenda_Minutes_071311/Agenda_Item_11.b._AIM_Adm_Vendor_Perf_June_2011_Summary.pdf

Use of Medi-Cal Fee-for-Service Delivery System

Ms. Casillas reported on Agenda Item 11.c, the Use of the Medi-Cal Fee-for-Service Delivery System for the AIM Program. This project has been discussed for a long time within the office and with the Board in the context of trying to keep the AIM program coverage statewide and open at least through 2014, when the Exchange opens. During the last two years in particular, AIM has been very challenging with health care costs increasing and the plans passing these costs on to MRMIB. Costs of hospitalizations have been particularly challenging for our health plan partners.

When AIM was first established, it was created as a program for pregnant women that did not qualify for Medi-Cal and it was supposed to look like commercial coverage. The hospitals took that literally and said they should get commercial rates. Perhaps in the past they may have thought they did, but clearly as money has gotten tight in this state staff has come to the realization that AIM is not a commercial program. AIMit is a public program and it is publicly funded. AIM enrollment is limited; the Board serves 7,000 to 10,000 women in a given year. With that enrollment spread across about five different health plans, it is hard to achieve any savings within any given .

Chairman Allenby noted the issue of risk with this population and Ms. Casillas agreed, noting that every AIM subscriber is hospitalized at least once. Mr. Figueroa said that this meant a 100 percent utilization rate among the AIM population.

Ms. Casillas said that the bottom line is that AIM has been difficult for the health plans and for MRMIB. Revenues for the program have declined as the sale of cigarettes has declined, reducing Proposition 99 resources.She noted that this was a positive occurrence overall.

The idea of renting the Medi-Cal Fee-for-Service Delivery System in an effort to keep AIM open and running has been under discussion for some time. MRMIB would continue to conduct eligibility in the same manner it does today, charging the same premiums as are charged today. The difference is that pregnant women coming into the program would use the Medi-Cal Fee-for-Service Delivery System instead of receiving care through the health plans currently under contract with MRMIB.

Ms. Casillas noted that the timing for this proposal could not be worse given all the other issues around transitioning other MRMIB programs into Medi-Cal, which raised a lot of concerns about the Medi-Cal Fee-for-Service Delivery System in general. Staff continues to reach out to advocates for assistance in looking at ways to make this process work. The draft regulations in today's Board packet represent the first attempt at regulations to allow MRMIB to go down this path with AIM.

There were statutory changes in the last budget process, which will allow MRMIB to use the Medi-Cal Delivery System and use those Medi-Cal rates, but there is more work to do. The draft regulationsinclude two sections that basically say there is a lot more work is needed, specifically around the appeal rights if services are denied. MRMIB will reach out to maternal and child health advocates and ask them to provide some insights on these issues. These advocates are very

interested in how this is going to play out.

MRMIB also has questions for Medi-Cal and needs DHCS's assistance in thinking about this challenge and about how the state can make this work in the aresa of denied services and mental health services. Staff acknowledges the draft regulations as a first cut. Their purpose is to give the audience a broader view of where and why the state is headed down this path. Staff looks forward to meeting with Maternal and Child Health Access representatives, who could not be at today's meeting. MCHA has provided a letter of concern, which we are sharing with the Board today.

MRMIB staff will be discussing all these issues with MCHA, and will actively engage their representatives in meetings to resolve any outstanding issues in order to move forward with this revised program. MRMIB envisions that the changes would go into effect October 1 for new subscribers. There would be some overlap with women already in AIM under the old system during their pregnancies and up to the 60 days post partum.

The goal is to continue to offer program benefits as they are today, with the same benefits and coverage period. There is no intention to offer a program that would do anything less than what we do today.

Chairman Allenby asked if there were any questions or comments from the Board. Hearing none, he asked if there were any questions or comments from the audience. There were none.

The AIM Use of Medi-Cal Fee-for-Service Delivery System document is located at: http://mrmib.ca.gov/MRMIB/Agenda_Minutes_071311/Agenda_Item_11._c_AIM_Use_of_Medi_Cal_FFS_Delivery_System.pdf and http://mrmib.ca.gov/MRMIB/Agenda_Minutes_071311/Agenda_Item_11.d._ER_3_11_AIM_Emergency_Regulation_Text.pdf

Chairman Allenby asked if there was anything else to bring before the board. Ms. Casillas said there was not. The meeting was adjourned at 12:18 p.m.